BlueCross BlueShield of Arizona
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MEDICAL COVERAGE GUIDELINES
SECTION: VISION

ORIGINAL EFFECTIVE DATE: 11/26/13
LAST REVIEW DATE:
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

PHOTOTHERAPEUTIC KERATECTOMY (PTK)

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

Description:

Phototherapeutic keratectomy (PTK) involves the use of the excimer laser to treat visual impairment or irritative symptoms relating to diseases of the anterior cornea by sequentially ablating uniformly thin layers of corneal tissue. PTK may be performed in the office setting using topical anesthesia. PTK is distinguished from photorefractive keratectomy, which involves the use of the excimer laser to correct refractive errors of the eye (i.e., myopia, astigmatism, hyperopia, and presbyopia).

PHOTOTHERAPEUTIC KERATECTOMY (PTK) (cont.)

Criteria:

For photorefractive keratectomy, see BCBSAZ Medical Coverage Guideline, "*Ophthalmology Procedures".*

- Phototherapeutic keratectomy is considered ***medically necessary*** for treatment of visual impairment and/or irritative symptoms that are the result of **ANY** of the following conditions:

  1. Corneal scars
  2. Dystrophies that extend beyond the surface epithelial layer
  3. Opacities
  4. Recurrent corneal erosion that has failed conservative treatment

- Phototherapeutic keratectomy is considered ***not medically necessary*** for treatment of **ANY** of the following conditions:

  1. Epithelial membrane dystrophy
  2. Irregular corneal surfaces as the result of Salzmann's nodular degeneration or keratoconus nodules
  3. Superficial corneal dystrophy

- Phototherapeutic keratectomy for all other indications not previously listed is considered ***experimental or investigational*** based upon:

  1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  2. Insufficient evidence to support improvement of the net health outcome, and
  3. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives.

Resources:

Resources prior to 11/26/13 may be requested from the BCBSAZ Medical Policy and Technology Research Department.

1. 9.03.07 BCBS Association Medical Policy Reference Manual. Phototherapeutic Keratectomy. Re-issue date 02/10/2011, issue date 11/01/1998.

2. Chan E, Jhanji V, Constantinou M, Amiel H, Snibson GR, Vajpayee RB. A randomised controlled trial of alcohol delamination and phototherapeutic keratectomy for the treatment of recurrent corneal erosion syndrome. *Br J Ophthalmol.* Jun 12 2013.